Youth With A Mission Oxford, New Zealand

YWAM Oxford Confidential Health Form (CfMS Students)

Please fill out this form, have it signed by your physician, and return it to us at:
YWAM Oxford
PO Box 47
Oxford 7443 NEW ZEALAND
Fax: +64 3 312 4955
E-mail : registrar@ywamoxford.org

Applicant's name:

Blood type (if known):

Health History

How would you rate your overall health?

Excellent ☐ Good ☐ Fair ☐ Poor ☐

Do you have any illness or condition (past or present) we should be aware of?	Yes ☐	No ☐
Are you presently under a doctor's care for an illness or condition?	Yes ☐	No ☐
Are you currently taking any medication?	Yes ☐	No ☐
Do you have any allergies that we should be aware of?	Yes ☐	No ☐
Do you have any physical impairments, handicaps, or health conditions which require special accommodation:	Yes ☐	No ☐
Do you have any special dietary requirements?	Yes ☐	No ☐

If you answered yes to any of the above questions please provide details below:

Immunizations
Please write the date of the last immunization for each of the following:

Hepatitis A (last 2) _____ _____

Hepatitis B (last 3) _____ _____ _____

Typhoid _____

Tetanus/Diphtheria _____

Measles/Mumps/Rubella _____

Polio _____

Because the outreaches take place in countries where you are at risk of contracting these diseases, we strongly recommend these vaccinations be up to date. When you go in for your shots, ask your doctor to record them in a traveler's immunization record. Please send us a copy, and bring the original with you. **If you refuse vaccinations for personal reasons, both you and your physician must sign below indicating that you have been informed of the risks involved.**

Applicant's signature: _____ Physician's signature:_____

To the Physician:

Please review the information the applicant has given in the above sections.

In your professional opinion, is the applicant physically and emotionally able to undertake 6 months of extended cross-cultural travel in developing nations?

Yes ☐ Yes with limitations ☐ No ☐

If you marked 'Yes with limitations' or 'No' please elaborate:_____

_____

Please use the space below to include any other information you think we should know:

_____

_____

_____

Physician's name and address or practice stamp:

Physician's signature (required):_____